FAQs from ADFM Webinar on AAMC's Project CORE

Updated 3/8/19

CORE sites/other care sites

- **Did any sites implement with FQHC Primary Care (contracted site) with intended improvement of access to specialists?**

  Yes, a few AMCs have extended eConsults to their FQHCs that are on the same instance of their EMR. They have seen good uptake and high provider satisfaction and have found eConsults to be an effective tool in enabling more timely access to specialty input for this population that can have many barriers to accessing care. There are other teams who are interested in this extension as well with the principal challenge being identifying the most provider-friendly tool for enabling eConsults across different EMRs/platforms (see questions below on this topic).

- **Any option to expand this beyond a single system? eg - seems to be great value for rural PCPs, but these doctors often not part of a large academic system...**
  - (response from participant) University of Utah provides their EPIC version to those rural sites to facilitate the referral relationship. They see it as worth the investment.
    - Do those practices retain their own identity/business model/ownership, or have they all become UofU employees?
      - They remain their own practice. There is an "intent" that is discussed to refer for appropriate on-site cases to UofU, vs another Tertiary/Quat site. Utah's catchment area is multi-state

  From AAMC – yes, most CORE AMCs are interested in how to expand eConsults to their community partners, though we do recommend getting it right first for your internal providers before opening up the program to providers outside of your health system. There are different business strategies as well as technologies that can be implemented to enable this "external pivot," including using tools available through the EMR vendor or through external vendors offering cloud-based platforms. The AAMC and several of our CORE AMCs that are beginning to pilot these approaches can share guidance on some of the strategic considerations and decision points that need to be considered in enabling external eConsults.

- **Is this an option for community practice/regional systems, or only academic health centers?**

  Yes, eConsults have broad applicability and utility across health systems and sites of care. While the CORE program focuses on implementation first within the health system, most teams are interested in how to extend eConsults to their regional practices as a tool to enable more timely access to specialty care for these providers and their patients. Several teams are also beginning to explore new use cases for eConsult, such as enabling more effective communication in the inpatient setting or for patients discharged to post-acute settings.

CORE cohort cost, logistics, & resources

- **How do we participate in the next cohort?**

  Please email Meaghan Quinn (mquinn@aamc.org) to receive additional information about the program and to schedule a call with our team. If your team is interested in moving forward, we have a brief application that provides us with some additional background on your institution as well as helps to ensure alignment around readiness and institutional priorities. We are currently assembling our next cohort, which will launch in 2019 (we anticipate one cohort to begin this spring and one to begin in the fall). Most AMCs elect to engage with us for a two-year period.

- **When is cohort proposal interest best communicated, and what is process?**

  We are taking applications on a rolling basis and are happy to meet now with any teams who are interested in talking more about how CORE might align with your institution's goals and priorities and to discuss ideal timing to start (please email Meaghan Quinn mquinn@aamc.org for more information and to schedule a call). As noted above, we typically hold an informational call with key stakeholders/decision makers at an AMC first, and then if the team is interested, have a brief application that provides us with some additional background and ensures alignment across our teams in terms of goals and readiness/timing.

- **Is there a Project Management Plan infrastructure developed that we have access to?**

  We have a set of resource modules to help support your program implementation activities, including establishing your project plan, specialty selection and template development, PCP engagement, quality assurance, and data monitoring and evaluation. We host monthly collaborative calls that include didactic learning as well as opportunities for teams to share successes and brainstorm challenges. We also hold regular 1:1 calls with the AAMC team and the local CORE team and conduct a site visit early on with a clinical lead from another CORE team to support your implementation efforts. Finally, we convene the project managers for regular calls to connect on project management issues and updates.

- **Because funding [CMMI] has ended, what budget information do you have for cost to bring online?**

  We have recommended staffing requirements for the project team that include a primary care clinical lead (typically 0.2-0.3 FTE), a program manager (typically 0.5-1.0), the IT build lead, and a data analyst/report generator (typically 0.2 FTE). In addition, all CORE AMCs have committed to providing a 0.5 wRVU credit or equivalent to the PCP and specialist eConsultant for a completed eConsult to recognize the effort it takes for the PCP to continue to manage that patient and implement the specialist's recommendations and the time it takes the specialist to review the chart and to provide their guidance on a contingency plan. As of January 2019, Medicare is now reimbursing PCPs and specialists for completed eConsults (0.7 wRVU each). Finally, the cost to participate in the AAMC collaborative is $60,000 total for two years or $40,000 if participating for just one year, which includes all of the benefits and services detailed in the attachment.

- **What metrics have been followed thus far in the cohorts underway?**
  All teams have monitored program uptake metrics, including eConsults completed by specialty, percent of eConsults that are declined or converted, percent "specialty contact," and PCP uptake (by department, provider type and clinic). Several of the later cohorts have also begun to look at PCP referral trends to participating CORE specialties and access to care metrics for participating CORE specialties. Teams have also assessed PCP and specialist satisfaction.

EMR

- **Must the Primary Care PCP and Specialist be "within" or using the same EMR? Example is both use EPIC, but not from the same institution.**

  We recommend that the AMC implement the program internally first for their primary care providers and specialists so that you can establish the workflows, develop a high reliability system, and establish processes for program monitoring and quality assurance before opening up to external PCPs. Some AMCs have begun to extend eConsults to outside PCPs, for example to their FQHCs or clinics within their Clinically Integrated Network that are on the same EMR instance. There are also tools from both the EMR vendors and other for-profit vendors that can be considered when a team is ready to make the "external pivot" and open up eConsults to affiliate partners/community practices.

- **Can you state which EMRs are currently set up for this?**
  To date, the majority of our AMCs have been on Epic and one is on Cerner (another has also built these tools in AllScripts). The CORE model, however, is EMR-agnostic and should be able to be adapted to other systems beyond the three listed here.

Program Impact

- **Have your cohort participants been able to show an ROI to keep CORE at least revenue neutral in regards to the RVU credits to specialists and PCP's? Thinking that there could be an offset with additional volume/access, more "total capture" of referrals in the system, and/or new payment options via payors - either direct or via value/shared-savings contracts.**

  All AMCs that have implemented the model, whether under the CMMI grant or self-funded, have seen the ongoing value of the program such that they continue to support the model and, in many cases, expand it further. The costs for the per-eConsult RVUs are rather trivial when compared to reduced no-shows, more new patients entering the specialty practices, higher surgical/ procedural yield, etc. One AMC developed a model to show the ROI by looking at the eConsult payments/credits verses the revenue of off-loading these lower acuity visits for higher acuity referrals to their participating specialties. They found the program to be cost effective. In our CMMI program evaluation, we saw a 5% increase in new patient visits by the primary care population to participating medical specialties, which is signal that eConsults are helping to avert a proportion of referrals that can continue to be managed in primary care. Finally, Medicare is now reimbursing for eConsults and several sites are also having success in engaging local Medicaid and commercial plans, including their self-insurers.